ATTACHMENT J - ACCOUNTABLE ENTITY TOTAL COST OF CARE REQUIREMENTS

Table of Contents

A. TCOC Definition

Total cost of care (TCOC) is a fundamental element to the Accountable Entity (AE) program. It includes a historical baseline cost of care projected forward to the performance period. Actual costs during the performance period are then compared to this baseline to identify a potential shared savings or risk pool.

Effective TCOC methodologies incentivize AEs to invest in care management and other services that address member needs and reduce duplication of services. In doing so, AEs improve health outcomes, lower costs, and earn savings. Savings in this program are also determined by performance against quality and outcomes metrics.

B. TCOC Methodology Goals

These TCOC guidelines support meaningful performance measurement and create financial incentives to reduce costs and improve quality. In order to accomplish meaningful performance measurement, this methodology:

- **Provides opportunity for a sustainable business model**
  This methodology creates ongoing opportunity for effective AEs by: (1) recognizing efficient historical performers; (2) allowing for shared savings to be retained for system investment; (3) creating greater financial incentives for being inside the AE program than for being outside the program
- **This methodology creates financial flexibility for AEs to** improve clinical pathways for Medicaid high utilizers and to address social drivers of health outcomes and costs
- **Is fiscally responsible for all participating parties** and adequately protect the solvency of the AEs and managed care organizations (MCOs) and the financial interests of the RI Medicaid Program
- **Specifically recognizes and addresses the challenge of small populations** through strategies that minimize the impact of small numbers, given the state's small size
- **Incorporates quality metrics** related to increased access and improved member outcomes
- **Requires timely data exchange and performance improvement reporting between MCOs and AEs**
- **Includes a progression toward meaningful provider risk**

C. General Requirements for Program Participants

1. **Minimum Membership and Population Size**
   MCOs may utilize TCOC-based payment models only with AEs that have at least 5,000 attributed Medicaid members across all MCOs and at least 2,000 members per MCO-AE contract.

2. **State/MCO Capitation Arrangement**
   The MCO retains the base contract with the State; the MCO medical capitation will be adjusted for savings/risk associated with the program as described in the State/MCO contract. This does not preclude MCOs from creating value-based purchasing arrangements with non-AE providers; however, those contracts would still be subject to the State gain-share and would not be included in the State's assessment of the MCO's value-based payment performance standards related to AEs.

3. **Exclusivity of Approved TCOC Methodologies**
   MCO TCOC arrangements shall supersede and be exclusive of any other TCOC-related shared savings arrangements with an AE or any of its constituent providers for Medicaid members.

4. **Attribution**
   AE specific historic base data must be based on the AE's attributed lives for a given period, in accordance with EOHHS defined attribution requirements, as defined separately. TCOC performance period data must account for and be aligned with the list of attributed members MCOs are required to generate on a monthly basis, as described in the attribution requirements.

D. TCOC Methodology

For PY6, EOHHS has established a standard methodology for total cost of care. An overview of the methodology is presented here. The full methodology is detailed in the *Total Cost of Care Technical Guidance*.

1. Establishing TCOC targets

For PY6, TCOC targets will include the following components:

- **a.** Historical cost data, including covered services that align with those included in EOHHS's contract with MCOs
- **b.** Adjustment for the changing risk profile of the population
- **c.** Adjustment for trend assumptions
- **d.** Adjustment to historical base relative to market average

2. Measuring Expenditures for the Performance Period

- **a. Calculate Actual Expenditures Consistent with the Historical Base Methodology**
  MCOs will calculate and report actual expenditures for the Performance Period consistent with the base methodology as described above.
- **b. Actual expenditures shall include all performance year costs for those members attributed to an AE**

3. Shared Savings/(Loss) Pool Calculations

The Shared Savings/(Loss) Pool shall be calculated as the difference between Actual

Expenditures and TCOC Expenditure Target after the following adjustments:

a**. Minimum Savings Rate**

EOHHS requires a minimum savings rate (MSR) to limit the potential for Shared Savings payments related to cost reductions generated strictly due to the effect of random variation in utilization and spending in small populations. The MSR by AE size is detailed in the *Total Cost of Care Technical Guidance*. The MSR only applies to shared-savings only contracts; there is no MSR in "two-sided" contracts where the AE takes on downside risk.

b. Impact of Quality and Outcomes

The Shared Savings Pool shall be adjusted based on an assessment of performance relative to a set of quality measures for the attributed population. An Overall Quality Score will be generated for each AE, according to the methodology detailed in *Attachment A: Quality Framework and Methodology for Comprehensive Accountable Entities.* The Total Shared Savings Pool (inclusive of both the AE and MCO portions) must be multiplied by the Overall Quality Score. The Overall Quality Score must function as a multiplier, and may not include a gate; as such, any quality points earned must be associated with a share of the Shared Savings Pool.

In PY6, the Shared Loss Pool shall also be adjusted based on the Overall Quality Score generated for each AE according to the methodology detailed in *Attachment A: Quality Framework and Methodology for Comprehensive Accountable Entities*. The Overall Quality Score will be divided by 4 and multiplied by the total Shared Loss Pool. The resulting product will be subtracted from the total Shared Loss Pool. For example, if the Overall Quality Score is 0.88, the multiplier will be 0.22. A Shared Loss Pool of $100,000 would be multiplied by 0.22, yielding $22,000, and the shared loss pool of $100,000 would be reduced by $22,000, yielding a final Shared Loss Pool of $78,000.

c. Risk Exposure Cap

The Risk Exposure Cap cannot be lower than specified minimum thresholds. The Risk Exposure cap can be expressed as a percentage of the AE-specific TCOC Expenditure Target[1] or as a percentage of the AE's revenue. [2] Savings or losses that exceed 10% in any program year will trigger a review by EOHHS to determine if all Performance

---

[1] The percentage of total cost of care is calculated based on the Final TCOC Target established by EOHHS as part of the final Program Year TCOC reporting. See the Total Cost of Care Technical Guidance for details on how the Final TCOC Target is established.

[2] Revenue of AE providers from the insurer under the contract refers to revenue paid by the insurer (MCO) to any Tax Identification Number that the AE identifies as participating in the AE. This is not limited to primary care practices or providers through whom Medicaid members are attributed to the AE, but rather refers to all providers that have signed AE participation agreements for the Program Year in question. The revenue for these providers is all revenue for services rendered to any Medicaid patient covered by the insurer and is not limited to members attributed to the AE. This does not include revenue for services rendered to patients covered by the Medicare-Medicaid Plan or any non-Medicaid product offered by the same insurer.

Period TCOC and target TCOC calculations are accurate. If the risk exposure cap is greater than or equal to 10%, the AE must present an actuarial analysis that estimates maximum potential loss. The actuarial analysis must be performed by an independent actuary and the results of the analysis be provided in a letter signed by the responsible actuary. This analysis will be used to substantiate the risk mitigation plan proposed by the AE. EOHHS reserves the right to revise any errors and adjust for unforeseen programmatic or data issues that may be contributing to overstated losses or savings.

For AEs assuming downside risk, the Maximum Shared Loss Pool will be defined by the Risk Exposure Cap agreed to by AE and MCO as part of the downside risk arrangement. The Risk Exposure Cap must meet the minimum requirement for transitioning to risk-based arrangements as specified below.

d. Global Cap

In instances where, in aggregate, the AEs Shared Savings/(Loss) Pool for a particular MCO is materially misaligned with the MCO's financial gains or losses related to benefit expenses, the Shared Savings/(Loss) Pool for the AEs may be adjusted. Each year, a Global Cap on the Shared Savings/(Loss) Pool for each MCO will be established based on the MCO's financial gain/loss on benefit expense, plus the risk margin related to benefit expenses that is incorporated in the capitation rates for that year. The calculation of the Global Cap and further details on the timing of this adjustment are outlined in the Total Cost of Care Technical Guidance for Program Year 6, Section 5.d.

4. AE Share of Savings/(Loss) Pool

In Program Year 6, AEs who assumed downside risk in Program Year 5 must be eligible to retain at least 60% of the Shared Savings Pool and must be responsible for at least 40% of any Shared Loss Pool. AEs new to downside risk in Program Year 6 must be eligible to retain at least 60% of the Shared Savings Pool and must be responsible for at least 30% of any Shared Loss Pool. AEs in shared savings-only models must be eligible to retain up to 50% of the Shared Savings Pool.

AE Shared Savings Model	AE Share of Savings	AE Share of Losses
Shared savings only	Up to 50% of Shared Savings Pool	N/A
Shared savings and risk: AEs that assumed downside risk in PY5	At least 60% of Shared Savings Pool	At least 40% of Shared Loss Pool
Shared savings and risk: AEs that did not assume downside risk in PY5	At least 60% of Shared Savings Pool	At least 30% of Shared Loss Pool

5. Required Progression to Risk-Based and Value-Based Arrangements

a. AEs qualified to assume downside risk

Certified AEs qualified to assume downside risk must demonstrate a progression of risk to include meaningful downside shared risk within three years of AE program participation, however PY3 was not counted towards these three years due to the COVID-19 emergency. New participants in the AE program will begin this progression at Year 1 levels of risk exposure and risk sharing. Federally Qualified Health Centers (FQHC)-based AEs new to downside risk in PY6 will assume risk consistent with the Year 4 standards described in the table below, even if they are in their sixth year in the program.

EOHHS has defined "meaningful risk" based on learnings from other states, OHIC requirements, and federal MACRA rules. The required progression of increasing risk for AEs qualified to assume downside risk is as follows:

	Shared Savings Cap *Maximum Shared Savings Pool*	**Minimum Risk Exposure Cap** *Maximum Shared Loss Pool*	**Risk Sharing Rate** *AE Share of Losses*
Definition	*A cap on the Shared Savings Pool, expressed as a percentage of the total cost of care*	*A cap on the Shared Loss Pool, expressed as a percentage of a) the total cost of care, or b) the annual revenue of AE providers from the insurer under the contract*	*The percentage of the Shared Loss Pool shared by the provider with the insurer under the contract after the application of the risk exposure cap*
Year 1	At least 10% of TCOC	N/A	0
Year 2	At least 10% of TCOC	N/A	0
Year 3	At least 10% of TCOC	N/A	0
Year 4/ AEs taking downside risk for the first time	At least 10% of TCOC	**At least** the lesser of 1% of TCOC; or 3% of AE Revenue	At least 30%
Year 5	At least 10% of TCOC	**At least** the lesser of 2% of TCOC; or 6% of AE Revenue	At least 40%
Year 6	At least 10% of TCOC	**At least** the lesser of 2% of TCOC; or 6% of AE Revenue	At least 40%

All AEs that agree to bear downside risk under Program Year 6 TCOC contracts must satisfy requirements of the two-part (pre-qualification and complete TCOC Financial Solvency Filing process) risk-bearing provider organization process to ensure that the AE has a risk mitigation plan sufficient to cover its maximum possible loss under such a contract. AEs that completed the TCOC Financial Solvency Filing process for PY5 are considered pre-qualified for PY6 and are not required to complete the PY6 Pre-Qualification application. **All AEs that agree to bear downside risk under PY6 TCOC contracts must complete the PY6 TCOC Financial Solvency Filing process.** Details of the pre-qualification and TCOC Financial Solvency Filing process for risk-bearing provider organizations is found in *Attachment B: Pre-Qualification of and TCOC Financial Solvency Filing for Accountable Entities Bearing Financial Risk.*

The Medicaid prospective payment system (PPS) established a methodology assuring FQHCs a minimum per visit reimbursement rate when providing care to Medicaid beneficiaries. States also have the option of using an alternative payment methodology (APM) so long as the medical payment rate is not lower than what would be paid under PPS. In Rhode Island, FQHCs are paid pursuant to an APM. EOHHS believes that FQHC-based AEs in Rhode Island can choose to engage in contracts with a level of risk pursuant to these requirements while remaining compliant with Federal rules.

An FQHC-based AE that enters into a downside risk contract would be subject to the same requirements as other AEs taking on downside risk with respect to the Shared Saving Cap and the process described in *Attachment B: Pre-Qualification of and TCOC Financial Solvency Filing for Accountable Entities Bearing Financial Risk*. However, FQHC-based AEs who take risk for the first time in PY6 will be subject to the Risk Exposure Cap and minimum Risk Sharing Rate that applied to other AEs in PY4. As noted above, this means a Risk Exposure Cap of 1% of TCOC or 3% of AE revenue, and a minimum Risk Sharing Rate of 30%.

b. AEs not assuming downside risk

FQHCs are not required to take on the downside risk option described above. FQHC-based AEs may remain in shared savings-only contracts if they progress towards value-based care and alternative payments through an EOHHS-approved project designed to generate healthcare cost savings. Requirements for such projects are outlined in *"ATTACHMENT K – INFRASTRUCTURE INCENTIVE PROGRAM: REQUIREMENTS FOR MANAGED CARE ORGANIZATIONS AND CERTIFIED ACCOUNTABLE ENTITIES."*

E. TCOC Reporting Requirements

In order to monitor AE financial performance, MCOs are required to furnish to EOHHS and AEs on a quarterly basis reports regarding TCOC performance. The reports must include, by rate cell, summarized TCOC expenditures and member months for attributed members over a recent 12-month period. See *Accountable Entity Program Total Cost of Care Technical Guidance* for Program Year 6 for reporting dates.

Attachment A: Quality Framework and Methodology for Comprehensive Accountable Entities

A. Principles and Quality Framework

A fundamental element of the EOHHS Accountable Entity (AE) program, and specifically the transition to alternative payment models, is a focus on quality and outcomes. Measuring and rewarding quality as part of a value-based model is critical to ensuring that quality is maintained and/or improved while cost efficiency is increased. As such, the payment model must be designed to both recognize and reward historically high-quality AEs while also creating meaningful opportunities and rewards for quality improvement. This model must be measurable, transparent and consistent, such that participants and stakeholders can view and recognize meaningful improvements in quality as this program unfolds. The program requirements are intended to provide structure that permits baseline measurement and assessment, while allowing for future refinements that continuously "raise the bar" toward critical improvements in quality and outcomes.

B. Impact of Quality Performance on Shared Savings and Losses

Medicaid AEs are eligible to share in earned savings and will contribute toward shared losses based on a quality multiplier (the "Overall Quality Score") to be determined as follows:

- AE performance on total cost of care (TCOC) as determined using the EOHHS approved TCOC methodology will determine whether the AE is eligible for shared savings or must contribute to shared losses.
- In accordance with 42 CFR §438.6(c)(2)(ii)(B)[3], quality performance measurement must be based on the Medicaid Accountable Entity Common Measure Slate. EOHHS expects that performance on each measure be reported annually for the full quality measure performance year.
- For comprehensive AEs, all admin (claims-based) measures must be generated and reported by the MCO. AEs must provide the necessary data to the State Quality Reporting System (QRS) to generate any hybrid or EHR-only measures. Any EHR-only non-HEDIS measure is defined to include only active patients in the denominator. Active patients are individuals seen (either through an in-person office visit or telephone visit, e-visit or virtual check-in) by a primary care clinician associated with the AE anytime within the last 12 months.
- An Overall Quality Score must be generated for each AE. The Overall Quality Score will be used as a multiplier to determine the percentage of any Shared Savings Pool the AE and MCO are eligible to receive. In PY6, the Overall Quality Score will also be used to determine the percentage of any Shared Loss Pool the AE and MCO will have to pay. The Overall Quality Score will be divided by 4 and multiplied by the total Shared Loss Pool. The resulting product will be subtracted from the total Shared Loss Pool. For example, if the Overall Quality Score is 0.88, the multiplier will be 0.22. A Shared Loss Pool of $100,000 would be multiplied by 0.22, yielding $22,000,

[3] https://www.ecfr.gov/cgi-bin/text-idx?SID=85dc983b09de39869ece9ee0d34d0a09&mc=true&node=se42.4.438_16&rgn=div8.

and the Shared Loss Pool of $100,000 would be reduced by $22,000, yielding a final Shared Loss Pool of $78,000. Overall Quality Scores must be calculated distinctly for each MCO with which the AE is contracted.

- Performance year periods, which are aligned with the state fiscal year calendar, will be tied to the calendar year quality performance period ending within the performance year period. Benchmark periods used to set targets for achievement and improvement will depend on data availability and appropriateness and may be adjusted in case of unusual circumstances such as the COVID-19 pandemic.

Performance Year	Performance Time Period	Quality Measurement Performance Period	Quality Measurement Benchmark Period	Payment
PY 1	SFY 2019	HEDIS 2019, CY 18	HEDIS 2018, CY 17	SFY 2020
PY 2	SFY 2020	HEDIS 2020, CY 19	HEDIS 2019, CY 18	SFY 2021
PY 3	SFY 2021	HEDIS Measurement Year (MY) 2020, CY 20	HEDIS 2020, CY 19	SFY 2022
PY 4	SFY 2022	HEDIS MY 2021, CY 21	HEDIS MY 2018 and 2019, CY 18 and 19	SFY 2023
PY5	SFY23	HEDIS MY 2022, CY 22	HEDIS MY 2019 and 2020, CY 19 and 20	SFY 2024
PY6	SFY24	HEDIS MY 2023, CY 23	HEDIS MY 2020 and 2021, CY 20 and 21	SFY 2025

C. Medicaid AE Common Measure Slate for Comprehensive AEs

In accordance with 42 CFR §438.6(c)(2)(ii)(B)[5], quality performance measurement must be based on the Medicaid Comprehensive AE Common Measure Slate (see Section F below). The core measures must be reported for all measure that meet the eligible denominator sizes.
The Common Measure Slate for comprehensive AEs has been developed with the following considerations:

- Alignment with the RI OHIC core measure set.
- Cross cutting measures across multiple domains with a focus on clinical/chronic care, behavioral health, and social determinants of health.
- Feasibility of data collection and measurement and minimization of administrative burden.

[5] https://www.ecfr.gov/cgi-bin/text-idx?SID=85dc983b09de39869ece9ee0d34d0a09&mc=true&node=se42.4.438_16&rgn=div8.

- A minimum number of measures necessary to enable a concentrated effort and meaningful assessment of quality.
- Focus on statewide strategic priorities outlined by EOHHS, RI Department of Health, RI Department of Behavioral Healthcare, Developmental Disabilities and Hospitals, and the Office of the Health Insurance Commissioner.

D. Comprehensive AE Overall Quality Score Determination

As articulated in the Rhode Island Accountable Entity Program Total Cost of Care Quality and Outcome Measures Implementation Manual hereafter referenced as "Implementation Manual", EOHHS developed a standard quality score methodology to be used by all AEs and MCOs. The required TCOC Overall Quality Score methodology is as follows:

a. **Target Structure:** The Overall Quality Score recognizes AEs that either attain a high-achievement target or demonstrate a required level of improvement over prior performance. MCOs will assess AE performance on each Common Measure Slate P4P measure for both achievement and improvement. For each Common Measure Slate P4P measure, AEs will be awarded whichever score yields the greatest performance points. The maximum earnable score for each measure will be "1", and each measure will be weighted equally.
    a. Achievement targets:
        i. EOHHS will establish two achievement targets: "threshold" and "high."
        ii. Achievement points will be scored on a sliding scale for performance between the threshold and high values.
            1. If performance is below or equal to the threshold-performance target: 0 achievement points
            2. If performance is between the threshold-performance and the high-performance target, achievement points earned (between 0 and 1) will be determined based on the following formula: (Performance Score – Threshold Performance) / (High-Performance Target –Threshold Performance)
            3. If performance is above the high-performance target: 1 achievement point
    b. Improvement target:
        i. The improvement target will be measured at the AE/MCO dyad level and will be a fixed number of percentage points, with three percentage points as the default value.
            1. The value may vary from three percentage points if deemed appropriate by EOHHS.
            2. The value may be less than what would be required to demonstrate statistical significance in a given year.
        ii. Improvement as defined by 1.b.i will earn the AE a score of "1."

E. Calculation of the Overall Quality Score and TCOC Quality Benchmarks

Each MCO will sum the points earned across all measures for which the AE has an adequate denominator size and divide that sum by the number of measures for which there is an adequate denominator size. [6] For example, if an AE has an adequate denominator size for all AE Common Measure Slate measures, then the MCO would sum the scores for each of the nine measures and divide the result by 9.[7] This resulting quotient is the "Overall Quality Score." The MCO shall multiply the annual savings generated by the AE by the Overall Quality Score to determine the shared savings to be distributed to the AE. See Appendix F: Example Overall Quality Score Calculation for QPY6, in the accompanying, Implementation Manual, for illustration of this calculation and further details.

EOHHS will define the percentage of quality measures from the common measure slate needed to achieve full shared savings. **In setting this parameter, EOHHS' general principle is that AEs should be allowed to achieve the full share of shared savings without having to earn the maximum possible points, i.e., through hitting the high achievement or improvement targets for all ten measures.** EOHHS will also define the impact of quality performance on mitigation of shared losses. **In setting this parameter, EOHHS's general principle is that AEs should have any losses mitigated, but not eliminated, based on quality performance**.

EOHHS has adopted different approaches to set TCOC quality benchmarks based on the performance year.

For QPY3, negotiated AE and MCO QPY2 benchmarks were used to evaluate AE performance and inform the negotiated formula for distribution of shared savings.

For QPY4, EOHHS employed a combination of internal and external sources to set achievement targets. EOHHS set targets for Quality Performance Year 4 using Quality Performance Year 2 data, Quality Compass, Office of the Health Insurance Commissioner (OHIC) Patient Centered Medical Home (PCMH) Measure Survey Data in advance of Quality Performance Year 4.

For QPY5, EOHHS employed a combination of internal and external sources to set achievement targets. This includes, but is not limited to, (1) AE data from QPY2-QPY4, (2) national and New England Medicaid (HMO) data from NCQA Quality Compass 2020 (CY 2019 or CY 2018 data) and 2021 (CY 2020 data), (3) national and Rhode Island state data from CMS' 2019 and 2020 Child and Adult Health Care Quality Measures report and (4) Rhode Island practice-reported data for October 1, 2018 – September 30, 2019, October 1, 2019 – September 30, 2020 and October 1, 2020 – September 30, 2021 from the OHIC PCMH Measures Survey.

AE Quality Performance Year 2-4 data will be used to ensure the following guiding principles are met: 1) the high achievement target should be attainable for at least some AEs; 2) the high

[6] An adequate denominator size is defined as a minimum denominator of 30. This is consistent with NCQA guidelines per the HEDIS MY 2020 and MY 2021 Volume 2: Technical Update.
[7] Weight Assessment and Counseling for Children and Adolescents is assessed as one measure. The measure is a composite, created by averaging the scores of the three individual measure components 1) BMI percentile, 2) counseling for nutrition, and 3) counseling for physical activity.

achievement target should not exceed a value that represents a reasonable understanding of "high performance"; and 3) the high achievement target should not be below the current performance of every single AE.

For QPY6, EOHHS will employ a combination of internal and external data sources to set achievement targets for QPY6. EOHHS will set targets for QPY6 by January 2023 using (1) AE data, as reported by MCOs, from QPY4 (2021), (2) national and New England Medicaid (HMO) data from NCQA Quality Compass 2022 (CY 2021 data), (3) national and Rhode Island state data from CMS' 2021 Child and Adult Health Care Quality Measures report and (4) Rhode Island practice-reported data for October 1, 2020 – September 30, 2021 from the OHIC PCMH Measures Survey.

Should benchmark data be unavailable for a given measure, EOHHS will convene a meeting of AEs, MCOs, and clinicians to review the measure and determine appropriate benchmarks. As MCOs and AEs began transitioning in QPY3 to using electronic clinical data exchange for generation of those Common Measure Slate measures requiring clinical data, EOHHS anticipates that MCOs will use different data collection techniques with different AEs (see "Data Collection and Reporting Responsibilities" in the accompanying Implementation Manual). EOHHS will assess the impact of different data collection techniques on AE performance on Common Measure Slate measure results. Should different data collection techniques appear to have substantive systemic effects on AE performance on some or all of those measures requiring clinical data, EOHHS will modify benchmarks for affected AEs using its best judgement.

F. Comprehensive AE Common Measure Slate*

Measures	Steward	Data Source[8]	Specifications	AE Common Measure Slate[9]		
				QPY4 Reporting and Incentive Use	QPY5 Reporting and Incentive Use	QPY6 Reporting and Incentive Use
HEDIS Measures						
Breast Cancer Screening	NCQA	Admin	Current HEDIS specifications: QPY4: HEDIS MY 2021 QPY5: HEDIS MY 2022 QPY6: HEDIS MY 2023	P4P	P4P	P4P
Child and Adolescent Well-Care Visits (adolescent age stratifications only)	NCQA	Admin		Reporting-only	P4P	P4P
Child and Adolescent Well-Care Visits (2 components: 3-11 years and total)	NCQA	Admin		Reporting-only	Reporting-only	Reporting-only[10]
Controlling High Blood Pressure	NCQA	Admin/ Clinical		P4P	P4P	P4P
Eye Exam for Patients with Diabetes	NCQA	Admin/ Clinical		P4P	P4P	P4P
Follow-up after Hospitalization for Mental Illness	NCQA	Admin		P4P – 7 days (30 days is reporting-only)	P4P – 7 days (30 days is reporting-only)	P4P – 7 days (30 days is reporting-only)
Hemoglobin A1c (HbA1c) Control for Patients with Diabetes: HbA1c Control (<8.0%)	NCQA	Admin/ Clinical		P4P	P4P	P4P
Lead Screening in Children	NCQA	Admin			P4R	P4P
Weight Assessment & Counseling for Physical Activity, Nutrition for Children & Adolescents	NCQA	Admin/ Clinical		P4P		
Non-HEDIS Measures (Externally Developed)						
Developmental Screening in the First Three Years of Life	OHSU	Admin/ Clinical	QPY4: CTC-RI/OHIC (December 2020 version)[11] QPY5-QPY6: CMS Core Set of Children's Health Care Quality Measures for Medicaid and CHIP[12]	P4P	P4P	P4P

[8] "Admin/Clinical" indicates that the measure requires use of both administrative and clinical data.
[9] Please refer to the May 21, 2021 version of the Implementation Manual for more information on the QPY1 and QPY2 measures and to the April 20, 2022 version for more information on the QPY3 measures.
[10] EOHHS will revisit adoption of the total rate as a P4P measure and the 3-11 years and adolescent age stratifications as reporting-only for QPY6 in fall 2022.
[11] http://www.ohic.ri.gov/documents/2021/April/Revised%20Measure%20Specifications%20Adult%20and%20Pedi%20CTC-OHIC%20December%202020%20clean.pdf
[12] https://www.medicaid.gov/medicaid/quality-of-care/downloads/medicaid-and-chip-child-core-set-manual.pdf

Measures	Steward	Data Source[8]	Specifications	AE Common Measure Slate[9]		
				QPY4 Reporting and Incentive Use	QPY5 Reporting and Incentive Use	QPY6 Reporting and Incentive Use
Screening for Depression and Follow-up Plan	CMS	Admin/ Clinical	QPY4: CMS MIPS 2021, modified by EOHHS (April 8, 2021 version) QPY5: CMS MIPS 2022, modified by EOHHS (February 14, 2022 version – included as Appendix B) QPY6: CMS MIPS 2023, modified by EOHHS (TBD)[13]	P4P for July 1, 2021 – December 31, 2021[14]	P4P	P4P
Tobacco Use: Screening and Cessation Intervention	AMA-PCPI	Admin/ Clinical	QPY4: CMS MIPS 2021 QPY5: CMS MIPS 2022 QPY6: CMS MIPS 2023	Reporting- only	Reporting-only	Reporting-only
Non-HEDIS Measures (EOHHS Developed)						
Social Determinants of Health Screening	EOHHS	Admin/ Clinical	QPY4: EOHHS (July 29, 2021 version) QPY5-QPY6: EOHHS (August 3, 2022 version – included as Appendix C)	P4P	P4P	P4P
Patient Engagement with an AE Primary Care Provider	EOHHS	Admin	QPY6: EOHHS (May 23, 2022 version – included as Appendix A)			Reporting-only

*Measures are subject to change based on the recommendations of OHIC's Measure Alignment Review Committee

[13] EOHHS will update the specifications for this measure for QPY6 in January 2023 when CMS MIPS 2023 specifications are available.
[14] EOHHS is only implementing this measure for half of QPY4 because of lack of consistent interpretation of "follow-up."

Attachment B: Pre-Qualification of and TCOC Financial Solvency Filing for Accountable Entities Bearing Financial Risk

i. Background

During early 2020, EOHHS required Accountable Entities (AEs) that were anticipating downside risk in their *future PY3 contracts* with Medicaid MCOs to submit a pre-qualification application and supporting documentation to Office of the Health Insurance Commissioner (OHIC) by January 15, 2020. (PY3 was the period July 1, 2020 through June 30, 2021.) OHIC reviewed each submission to determine if an AE was "pre-qualified" as having the financial capacity to bear an estimated amount of downside risk across all of its Rhode Island Medicaid MCO contracts for PY3. Because AEs ultimately did not execute PY3 contracts with downside risk, in PY4 EOHHS again required AEs to submit a pre-qualification application in advance of PY4 downside risk contracts. **For PY6, all AEs who were fully qualified to take on downside risk pursuant to the PY5 TCOC Financial Solvency Filing process are considered pre-qualified for downside risk in PY6. Accordingly, an AE is only required to complete the Pre-Qualification process described below if that AE was not fully qualified pursuant to the PY5 TCOC Financial Solvency Filing process**.

To ensure that AEs assuming downside risk in their *executed contracts* with Medicaid MCOs are able to cover any financial losses, EOHHS will continue to require that AEs complete the annual TCOC Financial Solvency Filing process to certify AEs for downside risk assumption. This Attachment B lays out both the Pre-Qualification process applicable to AEs that did not complete the PY5 TCOC Financial Solvency Filing process, as well as the Financial Solvency Filing process for PY6 (July 1, 2023 through June 30, 2024). EOHHS will review and assess the financial impact of downside risk associated across all of an AE's Medicaid MCO risk contracts.

ii. Pre-Qualification Process for AEs that were not fully qualified to take on downside risk under the PY5 TCOC Financial Solvency Filing process

a. AEs that must file for pre-qualification

EOHHS will maintain a single pre-qualification review process for all AEs that will be entering into arrangements that include shared losses and who were not fully qualified to take on downside risk under the PY5 TCOC Financial Solvency Filing process. This review will estimate the amount of downside risk the AE anticipates assuming in PY6 and whether the AE has an adequate combination of assets and insurance to cover the maximum risk exposure.

b. Requirements for Pre-Qualification

EOHHS will allow for flexibility in AEs' approaches to managing their risk exposure as long as the AE can document a thorough strategy for obtaining protection from estimated maximum potential losses. If an AE has a strong balance sheet, its strategy for covering maximum potential losses due to downside risk could include documenting that it has sufficient existing secured liquid assets and reinsurance to cover the maximum potential losses, with evidence that these funds are secured in a controlled or custodial account. Other organizations without available liquid assets to cover the maximum potential losses may need to develop a risk strategy portfolio consisting of several different approaches.

Strategies could include, for example, aggregate and individual stop loss insurance, corporate investors, provider partner organization contributions, insurer withholds, delegation of risk to contracted provider organizations, insurer-provided capital, securities in trust, and letters of credit. [15]

For AEs without the necessary secured liquid assets to cover their estimated maximum potential loss, EOHHS will require provision of copies of any agreements with organizations assuming some or all of the risk on behalf of the AE. Such agreements should, at a minimum, detail the financial arrangement, and the amount of risk being assumed by each organization. EOHHS will require that each AE submit documentation that it has taken adequate steps to cover the risk using a) secured assets in a custodial or controlled account(s), and/or b) a reinsurance policy which can be used to protect the interests of enrolled Medicaid members, and/or c) delegation of risk to one or more parties. Taken together, the value of these strategies should not be less than the potential maximum losses due to all downside risk contracts with Medicaid MCOs.

As part of the pre-qualification application, AEs will also be required to submit a planned process for ongoing monitoring of performance against the downside financial risk arrangements for the AE and any subcontracted entities assuming delegated risk.

c. Process for pre-qualification review

The process that EOHHS will follow in its pre-qualification review is outlined below in i-viii.

i. The AE submits its application to EOHHS with all supporting documentation by January 20, 2023.

ii. EOHHS determines the AE's actual and/or estimated maximum risk exposure for MCO contracts for PY6.

iii. EOHHS determines whether the AE has an adequate current or planned process for ensuring sufficient financial resources to protect it, and those entities with which it has a contracting affiliation and is sharing or intends to share downside risk, from the estimated maximum potential losses from all Medicaid MCO contracts with downside risk with one or more financial mechanisms (e.g., liquid assets, stop-loss insurance, working capital and reserves, withhold arrangements or other financial mechanisms).

iv. EOHHS ensures that if the AE has liquid assets as part of its current or planned process to protect itself from the maximum potential losses, that the liquid assets are in a custodial or controlled account, which can be used exclusively to protect the interests of attributed Medicaid patients.

[15] The MCO should be the beneficiary of a surety bond or letter of credit.

v. EOHHS reviews the AE's current and/or planned process for ongoing monitoring of performance against downside financial risk arrangements and assurance of financial solvency and ensures that the process is acceptable.

vi. EOHHS reviews the AE's current and/or planned process for ongoing monitoring of any subcontracted provider entities assuming AE-delegated downside risk and ensures that process is acceptable.

viii. EOHHS notifies the AE by March 20, 2023 of its pre-qualification status. AEs can appeal the decision, in writing to EOHHS, within 30 days of its notification. AEs that choose not to appeal the decision but who would like to reapply for pre-qualification can do so by re-submitting the application and supporting documents addressing the concerns highlighted by EOHHS in the original application.

If at any time during its review EOHHS determines that it requires additional documentation, it will notify the AE in writing specifying the additional documentation needed.

d. Pre-Qualification Application Materials

Medicaid Accountable Entity Pre-Qualification Application

1. <u>AE Descriptive Information</u>

Rhode Island Medicaid Accountable Entity Organization Information

Name of Applicant: ____

The following information is required of the individual (within the Accountable Entity) who is designated to be the AE's primary contact for the pre-qualification process:

Title: ____________________________________

First Name: ______________________________Last Name: ______________________________

Position: ________________________________

Street or PO Address: _________________________

City: ______________________________________ State: ________ Zip Code: ______

E-mail Address: ____

Telephone: ______________________________

2. Provide a list of the names of the Medicaid MCOs with which the applicant will be entering into an arrangement to assume financial accountability for the full range, or nearly the full range, of an attributed MCO member population's health care needs.

   Please include contracts that will start in 2023. If contract negotiations are underway at the time of the application or are anticipated to begin but have not yet, indicate the status of negotiations and report anticipated risk arrangement terms.

   For each MCO contract, provide the nature of the reimbursement arrangement and the estimated number of attributed patient lives in PY6:

Name of MCO	Risk Arrangement Terms[16]	Aggregate Number of Attributed Patients and Associated Date
	PMPM budget: Provider Revenue: Risk Exposure Cap: Risk Sharing Rate:	
	PMPM Budget: Provider Revenue: Risk Exposure Cap: Risk Sharing Rate:	
	PMPM budget: Provider Revenue: Risk Exposure Cap: Risk Sharing Rate:	

3. Provide a statement that describes the applicant's experience to date in managing population-based contracts that hold the applicant organization financially responsible for a negotiated portion of costs that exceed a predetermined population-based total cost of care (TCOC) budget.

   ____
   ____
   ____

4. Please attach a plan that provides details of the applicant's processes and mechanism(s) for ensuring sufficient financial resources to protect a) the applicant and b) those provider entities with which it has subcontracted and intends to share downside risk, from the

[16] See Glossary of Terms at the back of Attachment B for definitions of the terms used in this table.

estimated potential maximum losses from downside risk associated with MCO contract(s) and AE subcontracts, respectively. AEs should also provide supporting documentation to demonstrate adequate protection against financial loss.

- Explain in this plan any intention to obtain insurance coverage or other agreements that protect the applicant from maximum potential losses from current downside risk, and a description of any other planned risk mitigation mechanisms including any aggregate stop-loss insurance, security deposits, working capital and reserves, withhold arrangements, etc.
- Distinguish current liquid assets from other mechanisms, including insurance coverage or other agreements that protect the applicant from potential maximum losses from future downside risk. If the AE is employing liquid assets as part of its plan to protect itself from maximum potential losses, those liquid assets must be in a controlled or custodial account to be used exclusively to protect the interests of attributed Medicaid patients. Applicant should provide evidence that the funds are in a controlled or custodial account. If the applicant intends to utilize a surety bond to protect the applicant from potential maximum losses from future downside risk, the bonding company must be certified by the U.S. Treasury.[17]
- If the applicant is planning a financial arrangement with any partner organization(s) that is assuming any of the applicant's downside risk, the partner(s) must execute a Parental Guarantee[18] document prior to applying for pre-qualification. The partner organization with which the AE is executing a Parental Guarantee should have a custodial or controlled account to cover losses. The AE should furnish documentation of the Parental Guarantee's custodial or controlled account.
- If the risk exposure cap is anticipated to be greater than or equal to 10%, the AE should address plans to present an actuarial analysis that estimates maximum potential loss. The actuarial analysis must be performed by an independent actuary and the results of the analysis be provided in a letter signed by the responsible actuary. This analysis will be used to substantiate the risk mitigation plan proposed by the AE.

5. Include a description of the applicant's current or planned process for ongoing monitoring of the applicant's financial risk arrangements and financial solvency. This process should include a timely review of the quarterly data reports received from the MCOs.

---

[17] https://fiscal.treasury.gov/surety-bonds/list-certified-companies.html.

[18] A Parental Guarantee is an agreement between an entity that controls a health care provider and the health care provider. It guarantees the performance of the provider's obligations under the financial risk transfer agreement including the payment of any amounts owed by the health care provider to participating providers for services rendered pursuant to a risk transfer agreement.

6. Include a description of mechanisms that are or will be put in place by the applicant to monitor the financial solvency of any provider entity(ies) with which it has a contracting affiliation and intends to share downside risk associated with MCO contract(s).

iii. PY6 TCOC Financial Solvency Filing, Review, and Assessment

a. AEs that Must File for Financial Solvency Review and Assessment

EOHHS will maintain a single review process for all AEs that have entered into arrangements that include shared losses. This review will assess the amount of downside risk the AE assumed in PY6 and whether the AE has an adequate combination of assets and / or other financial mechanisms (e.g., reinsurance, letter of credit) to cover the maximum risk exposure. The PY6 review will also assess an AE's performance in its PY5 risk contracts, as best understood at the time, to ensure adequate financial protections for a combined PY5 loss (if applicable) and PY6 maximum potential loss.

b. Requirements

EOHHS will allow for flexibility in AEs' approaches to managing their risk exposure as long as the AE can document a thorough strategy for obtaining protection from estimated maximum potential losses. If an AE has a strong balance sheet, its strategy for covering maximum potential losses due to downside risk could include documenting that it has sufficient existing secured liquid assets and reinsurance to cover the maximum potential losses, with evidence that these funds are secured in a controlled or custodial account. Other organizations without available liquid assets to cover the maximum potential losses may need to develop a risk strategy portfolio consisting of several different approaches. Strategies could include, for example, aggregate and individual stop loss insurance, corporate investors, provider partner organization contributions, insurer withholds, delegation of risk to contracted provider organizations, insurer-provided capital, securities in trust, and letters of credit. [19]

For AEs without the necessary secured liquid assets to cover their estimated maximum potential loss, EOHHS will require provision of copies of any agreements with organizations assuming some or all of the risk on behalf of the AE. Such agreements should, at a minimum, detail the financial arrangement, and the amount of risk being assumed by each organization. EOHHS will require that each AE submit documentation that it has taken adequate steps to cover the risk using a) secured assets in a custodial or controlled account(s), and/or b) a reinsurance policy which can be used to protect the interests of enrolled Medicaid members, and/or c) delegation of risk to one or more parties. Taken together, the value of these strategies should not be less than the potential maximum losses due to all downside risk contracts with Medicaid MCOs.

AEs must also submit a planned process for ongoing monitoring of performance against the downside financial risk arrangements for the AE and any subcontracted entities assuming delegated risk.

c. Process for Filing and Review

For PY6, AEs must submit to EOHHS a completed filing application (see attached template) and documents requested in the application, including the following:

[19] The AE should be the beneficiary of a surety bond or letter of credit.

a. Final executed AE/MCO contract for PY6 (July 1, 2023-June 30, 2024)
b. AE descriptive information
c. Final description of the financial risk arrangements (see Table 2 in the PY6 filing application)
d. Final description of experience managing financial risk to date
e. Current assessment of financial performance relative to PY5 risk arrangements, recognizing that claim runout and settlement processes will not yet be complete AEs should report the extent of their financial exposure if a loss is projected[20]
f. Final financial protection and risk mitigation processes / mechanisms
g. Final monitoring processes

Following submission of the final terms of the PY6 contract, EOHHS will review the financial risk arrangements, the AE's financial protections, and financial performance monitoring processes. The completed filing application, including contracts, is due to EOHHS by August 31, 2023. EOHHS will notify AEs who meet this deadline of their financial solvency certification status or communicate any concerns or additional information requests by November 1, 2023.
The process that EOHHS will follow in its review is outlined below in i-vii.

i. EOHHS determines the AE's actual maximum risk exposure for MCO contracts for the Performance Year.

ii. EOHHS determines whether the AE has sufficient financial resources to protect itself from the estimated maximum potential losses from all Medicaid MCO contracts with downside risk using one or more financial mechanisms (e.g., liquid assets, stop-loss insurance, working capital and reserves, withhold arrangements or other financial mechanisms). This assessment will factor in the AE's financial performance in PY4 downside risk arrangements to ensure adequate financial protections to cover the combined projected PY5 losses (as applicable) **and** maximum potential losses in PY6.

iii. EOHHS also determines whether those AE subcontracted entities with which the AE is sharing TCOC downside risk have sufficient financial resources to protect themselves from the estimated maximum potential losses from the AE's subcontract using one or more financial mechanisms.

iv. EOHHS ensures that if the AE has liquid assets as part of its current or planned process to protect itself from the maximum potential losses, that the liquid assets are in a custodial or controlled account, which can be used exclusively to protect the interests of attributed Rhode Island Medicaid patients.

v. EOHHS reviews the AE's current and/or planned process for ongoing monitoring of performance against downside financial risk arrangements and assurance of financial solvency and ensures that the process is acceptable.

[20] AEs will need demonstrate the capacity to fund PY5 losses and protect against future TCOC financial losses.

vi. EOHHS reviews the AE’s current and/or planned process for ongoing monitoring of any subcontracted provider entities assuming AE-delegated downside risk and ensures that process is acceptable.

vii. Communication of status of review: By November 1, 2023, EOHHS notifies the AE of successful certification or communicates any concerns and/or an additional information request related to the AE’s final risk terms. AEs can appeal the final decision, in writing to EOHHS, within 30 days of its notification. AEs that choose not to appeal the decision but would like to reapply for financial solvency certification can do so by re-submitting the application and supporting documents addressing the concerns highlighted by EOHHS in the original application.

If at any time during its review EOHHS determines that it requires additional documentation, it will notify the AE in writing specifying the additional documentation needed.

d. TCOC Financial Solvency Filing Application Materials

Medicaid Accountable Entity TCOC Financial Solvency Certification for PY6

Purpose: AEs should use this application to report the terms of their PY6 TCOC downside risk arrangements as executed in their contracts with Medicaid MCOs.

1. <u>AE Descriptive Information</u>

Rhode Island Medicaid Accountable Entity Organization Information

Name of Applicant: ____

The following information is required of the individual (within the Accountable Entity) who is designated to be the AE’s primary contact for the Financial Solvency Filing process:

First Name: ______________________________ Last Name: ____________________

Position: ________________________________

Street or PO Address: _________________________

City: _____________________________________ State: ________ Zip Code: ______

E-mail Address: ___________________________

Telephone: _______________________________

2. Provide a list of the names of the Medicaid MCOs with which the applicant executed a contract to assume financial accountability for the full range, or nearly the full range, of an attributed MCO member population's health care needs. Please include contracts for which the AE has accepted downside risk for any or all of PY6.

   For each MCO contract, provide the nature of the reimbursement arrangement and the estimated number of attributed patient lives in PY6.

AE/MCO Contract Risk Arrangement Terms for PY6[21]

Name of MCO	Risk Arrangement Terms of Executed Contracts	Aggregate Number of Attributed Patients and Associated Date
	PMPM budget: Provider Revenue: Risk Exposure Cap: Risk Sharing Rate:	
	PMPM Budget: Provider Revenue: Risk Exposure Cap: Risk Sharing Rate:	
	PMPM budget: Provider Revenue: Risk Exposure Cap: Risk Sharing Rate:	

[21] See Glossary of Terms at the back of Attachment B for definitions of the terms used in this table.

3. Provide a statement that describes the applicant's experience to date in managing population-based contracts that hold the applicant organization financially responsible for a negotiated portion of costs that exceed a predetermined population-based total cost of care (TCOC) budget.

____
____
____

viii. Report financial performance relative to PY5 risk arrangements across all Medicaid MCO contracts identified in the August 2022 certification application, as best known at the time of this filing.

Indicate if the applicant projects any losses under its PY5 risk arrangements.

Name of Medicaid MCO	Projected Risk Arrangement Loss for PY5 (Y/N)

ix. Please attach a plan that provides details of the applicant's processes and mechanism(s) for ensuring sufficient financial resources to protect a) the applicant and b) those provider entities with which it has subcontracted and intends to share downside risk, from the estimated potential maximum losses from downside risk associated with MCO contract(s) and AE subcontracts, respectively. AEs should also provide supporting documentation to demonstrate adequate protection against financial loss.

- Include in this plan evidence of any insurance coverage or other agreements that protect the applicant from maximum potential losses from current downside risk, and a description and evidence of the applicant's other risk mitigation mechanisms including any aggregate stop-loss insurance, security deposits, working capital and reserves, withhold arrangements, etc.
- Distinguish current liquid assets from other mechanisms, including insurance coverage or other agreements that protect the applicant from potential maximum losses from future downside risk. If the AE is employing liquid assets as part of its plan to protect itself from maximum potential losses, those liquid assets must be in a controlled or custodial account to be used exclusively to protect the interests of attributed Medicaid patients. Applicant should provide evidence that the funds are in a controlled or custodial account. If the applicant intends to utilize a surety bond to protect the applicant from potential maximum losses from future downside risk, the bonding company must be certified by the U.S. Treasury.[22]

[22] https://fiscal.treasury.gov/surety-bonds/list-certified-companies.html.

- If the applicant is planning a financial arrangement with any partner organization(s) that is assuming any of the applicant's downside risk, the partner(s) must execute a Parental Guarantee[23] document prior to applying for pre-qualification. The partner organization with which the AE is executing a Parental Guarantee should have a custodial or controlled account to cover losses. The AE should furnish documentation of the Parental Guarantee's custodial or controlled account.
- If the risk exposure cap is greater than or equal to 10%, the AE must present an actuarial analysis that estimates maximum potential loss. The actuarial analysis must be performed by an independent actuary and the results of the analysis be provided in a letter signed by the responsible actuary. This analysis will be used to substantiate the risk mitigation plan proposed by the AE.

x. Include a description of the applicant's current or planned process for ongoing monitoring of the applicant's financial risk arrangements and financial solvency. This process should include a timely review of the quarterly data reports received from the MCOs.

xi. Include a description of mechanisms that are or will be put in place by the applicant to monitor the financial solvency of any provider entity(ies) with which it has a contracting affiliation and intends to share downside risk associated with MCO contract(s).

[23] A Parental Guarantee is an agreement between an entity that controls a health care provider and the health care provider. It guarantees the performance of the provider's obligations under the financial risk transfer agreement including the payment of any amounts owed by the health care provider to participating providers for services rendered pursuant to a risk transfer agreement.

Glossary of Terms

Parental Guarantee - An agreement between an entity that controls a health care provider and the health care provider. It guarantees the performance of the provider's obligations under the financial risk transfer agreement including the payment of any amounts owed by the health care provider to participating providers for services rendered pursuant to a risk transfer agreement.

Partner Organization - An entity that will be assuming some of the AE's downside risk. It may be, but is not limited to, a corporate parent or otherwise related corporate entity, an investor, a business partner, or a delegated provider entity that delivers health care services to the AE's attributed patients. A delegated physician or other professional provider is not a partner organization if the totality of its assumption of AE risk is borne through a payment withhold.

PMPM (Per Member Per Month) Budget – A prospectively defined spending target associated with an Accountable Entity's (AE) attributed population, wherein spending is defined on an average monthly per capita basis, or "per member per month." For pre-qualification, PMPM budget can be estimated using the latest available TCOC targets.

Provider Revenue – Revenue of AE providers from the insurer under the contract refers to revenue paid by the insurer (MCO) to any Tax Identification Number that the AE identifies as participating in the AE. This is not limited to primary care practices or providers through whom Medicaid members are attributed to the AE, but rather refers to all providers that have signed AE participation agreements for the Program Year in question. The revenue for these providers is all revenue for services rendered to any Medicaid patient covered by the insurer and is not limited to members attributed to the AE. This does not include revenue for services rendered to patients covered by the Medicare-Medicaid Plan or any non-Medicaid product offered by the same insurer.

Risk Exposure Cap - This is a cap on the losses the organization may incur under the contract, expressed as a percentage of a) the total cost of care or b) the annual service revenue from the insurer under the contract. It is the maximum percentage of the organization's contract revenue for which the organization is financially at risk.

Risk Sharing Rate - Also called the Marginal Risk. This is the percentage of total losses shared by the organization with the insurer under the contract after the application of any risk exposure cap and/or minimum loss rate. It is the percentage of any Shared Loss Pool for which the organization is financially at risk.

Stop Loss Insurance (aggregate/specific) - Aggregate stop-loss insurance is a policy designed to limit claim coverage (losses) to a specific amount. This coverage ensures that a catastrophic claim (specific stop-loss) or numerous claims (aggregate stop-loss) do not drain the financial reserves of the organization.

Total Cost of Care - A historical baseline or benchmark cost of care specifically tied to an Accountable Entity's (AE) attributed population projected forward to the performance period.

Withhold Arrangement - A withhold arrangement is characterized by the insurer withholding the amount of money at risk until the contracting organization furnishes services to the members and meets certain quality and/or cost standards.